SECTION 10
FAMILY PLANNING SERVICES

Family planning is defined as any medically approved diagnosis, treatment, counseling, drug, supply, or device prescribed or furnished by a provider to individuals of child-bearing age to enable such individuals to freely determine the number and spacing of their children.

When billing family planning services, providers must:

- Use a diagnosis code in the range of V25 through V25.9; and
- Enter "FP" in field 24H on the CMS-1500 or the appropriate field if billing electronically.

COVERED SERVICES

A provider may bill as a family planning service the appropriate office visit code which includes one or more of the following services.

- Obtaining a medical history
- A pelvic examination
- The preparation of smears such as a Pap Smear
  Note: Obtaining a specimen for a Pap smear is included in the office visit. Screening and interpretation of a Pap smear can be reimbursed only to a clinic or certified independent laboratory employing an approved pathologist, or to an individual pathologist.
- A breast examination
- All laboratory and x-ray services provided as part of a family planning encounter are payable as family planning services.
- A pregnancy test would be family planning related if provided at the time at which family planning services are initiated for an individual, at points after the initiation of family planning services where the patient may not have properly used the particular family planning method, or when the patient is having an unusual response to the family planning method.
- HIV blood screening testing performed as part of a package of screening testing and counseling provided to women and men in conjunction with a family planning encounter is reimbursable as a family planning service.

COPPER INTRAUTERINE DEVICE (IUD) (PARAGARD T380 – A)

The fee for procedure code 58300 covers insertion of the IUD. Procedure code J7300, Intrauterine Copper Contraceptive, should be billed for the purchase of the IUD. A copy of the invoice indicating the type and cost must be attached to the claim for manual pricing.

Code J7300 is to be used by physicians, nurse practioners, nurse midwives, federally qualified health centers (FQHCs) and provider based Rural Health Clinics (RHCs). A National Drug Code (NDC) should **not** be used to bill for the device.

The appropriate office visit procedure code may be billed for the removal of the IUD. (Procedure code 58301 is not a billable procedure as payment for the service is included in the office visit procedure code.)

LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM (MIRENA)

Physicians, nurse practitioners, and nurse midwives must bill for the system on the Pharmacy Claim form using the National Drug Code (NDC).

FQHCs and Provider Based RHCs bill using procedure code J7302.

DIAPHRAGMS OR CERVICAL CAPS

The fitting of a diaphragm or cervical cap is included in the fee for an office visit procedure code. The cost of the diaphragm can be billed using procedure code A4266. The cost of the cervical cap can be billed using procedure code A4261. An invoice indicating the type and cost of the items must be sent with claims for these services for manual pricing.

NORPLANT SYSTEM

The following procedure codes are for insertion only, removal only, or removal with reinsertion only and do not include reimbursement for the device.

11975 - insertion, implantable contraceptive capsules
11976 - removal, implantable contraceptive capsules
11977 - removal, implantable contraceptive capsules with reinsertion

All providers except FQHCs, provider-based RHCs, and hospitals (outpatient services) must bill the Norplant device on the Pharmacy Claim form using the package NDC number. FQHCs and provider-based RHCs must bill procedure code A4260 for the Norplant device.

An office visit code may not be billed in addition to any of the Norplant procedure codes.

VAGINAL RING

Physicians, nurse practitioners, and nurse midwives must bill for the item on the Pharmacy Claim form using the National Drug Code (NDC).

FQHCs and Provider Based RHCs bill using procedure code J7303.

DEPO-PROVERA INJECTIONS

Depo-Provera injections should be billed on the Pharmacy Claim Form using the National Drug Code (NDC). FQHCs and provider based RHCS bill the injection using the appropriate injection “J” code.

STERILIZATIONS

A *Sterilization Consent* form (a copy of the form is in the Forms section of this publication) is a required attachment for all claims containing the following procedure codes: 55250, 58600, 58605, 58611, 58615, 58670, and 58671. **The Medicaid recipient must be at least 21 years of age at the time the consent is obtained and be mentally competent.** The recipient must have given informed consent voluntarily in accordance with Federal and State requirements.

The *Sterilization Consent* form must be completed and signed by the recipient at least **31** days, but not more than **180** days, prior to the date of the sterilization procedure. There must be **30** days between the date of signing and the surgery date. The day after the signing is considered the first day when counting the 30 days. There are provisions for emergency situations (reference Section 10.2.E(1) of the *Medicaid Provider Manua*l available on the internet at www.dss.mo.gov/dms).

Essure - The Essure procedure is a new permanent birth control alternative without incisions into the abdomen and any sutures or long postoperative recovery period. Essure is a device that is inserted into each fallopian tube which once incorporated into the fallopian tube, causes a localized tissue reaction. The body tissue grows into the micro-inserts, blocking the fallopian tubes.

Missouri Medicaid covers the Essure procedure in the inpatient or outpatient hospital setting only with procedure code 58565. The *Sterilization Consent* form must be completed and signed at least 30 days prior to the sterilization.

SERVICES FOR WOMEN FOLLOWING THE END OF PREGNANCY - MEDICAL ELIGIBILITY (ME CODE 80)

Services for medical eligibility code “80" are limited to family planning, and testing and treatment of Sexually Transmitted Diseases (STDs) and are provided on a fee-for-service basis only. The treatments of medical complications occurring from the STD are **not** covered for this program. The co-pay requirement does not apply to ME code “80".

Women with ME Code 80 are not eligible for HCY benefits and procedure codes with the EP modifier designating an HCY service are not covered.

Covered Procedure Codes For ME “80"

Code	Description
A4260	Levonorgestrel (Norplant) (FQHC & provider-based RHC only)
A4261	Cervical cap (invoice required with claim)

A4266	Diaphragm (invoice required with claim)
J1055	Injection - Medroxyprogesterone acetate (Depo-Provera), 150 mg (FQHC & provider- based RHC only)
J7300	IUD (invoice required with claim) (FQHC and Provider Based RHC only)
J7302	Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 mg (FQHC and provider-based RHC only)
J7303	Contraceptive vaginal ring (FQHC and Provider Based RHC only)
J7304	Contraceptive hormone patch (FQHC and Provider Based RHC only)
Q0111	Wet mounts (PPMP CLIA List)
T1015	Rural health clinic encounter (independent RHC)
00400	Anesthesia for procedures on anterior integumentary system of chest including subcutaneous tissue
00851	Aesthesia for intraperitoneal procedure in lower abdomen including laparoscopy, tubal ligation/transection
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium
11975	Insertion Norplant
11976	Removal Norplant
11977	Removal with reinsertion - Norplant
58300	Insertion IUD
58565	Hysteroscopy, sterilization
58600	Ligation or transection of fallopian tubes
58605	Ligation or transection of fallopian tubes, postpartum
58611	Ligation or transection of fallopian tubes, at time of C-section
58615	Occlusion of fallopian tubes by device
58670	Laparoscopy with fulguration of oviducts
58671	Laparoscopy with occlusion of oviducts by device
99070	Supplies and materials over and above those usually included with office visit (requires invoice with claim)
99201-99215	Evaluation and management office/outpatient procedures (Do **not** use the EP modifier with these codes.)
99383-99387	Initial comprehensive preventive medicine (new patient) (Do **not** use the EP modifier with these codes.)
99393-99397	Periodic comprehensive preventive medicine (established patient) (Do **not** use the EP modifier with these codes.)
Lab procedures	Pap tests, tests to identify a STD, urinalysis, and blood work related to family planning or STDs.

Medically necessary diagnostic imaging

Covered Diagnosis Codes For ME “80"

V25-V25.9	Encounter For Contraceptive Mgt
V72.31	Gynecological Exam
V73.8-V73.88	Other Specified Viral and Chlamydial Diseases
V73.9-V73.98	Unspecified Viral and Chlamydial Disease
V74.5	Venereal Disease
054.1-054.19	Genital Herpes

091-091.2, 092-092.9	Syphilis
098-098.19	Gonococcal Infections
099-099.9	Other Venereal Diseases

Covered Birth Control Products

Progestational Agents	Contraceptives, Implantable
Contraceptives, Oral	Contraceptives, Injectable

Drugs Used To Treat STDs

Keratolytics	Aminoglycosides	Penicillins
Absorbable Sulfonamides	Vaginal Antifungals	Antifungal Agents
Probenecid	Tetracyclines	Vaginal Antibiotics
Topical Antiparasitics	Macrolides	Lincosamides
Topical Antivirals	Cephalosporins	Quinolones
Antivirals, General		